Perspectives

The Healthy Cities approach — reflections on a framework for improving global health

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The roots of the Healthy Cities concept may be traced back to 1844, when the Health of Towns Association was formed in the United Kingdom to deliberate on Edwin Chadwick's reports about poor living conditions in towns and cities. The revival of those concerns in the "new public health" era dates from the Healthy Toronto 2000 convention in 1984 and, subsequently, the enthusiasm of the World Health Organization (WHO) Regional Office for Europe to translate its principles into a tangible global programme of action to promote health. WHO defines a Healthy City as "one that is continually developing those public policies and creating those physical and social environments which enable its people to mutually support each other in carrying out all functions of life and achieving their full potential".

This philosophy seeks to enhance the holistic well-being of people who live and work in cities, based on four criteria: (a) explicit political commitment at the highest levels to the principles and strategies of a Healthy Cities project; (b) establishment of new organizational structures to manage change; (c) commitment to developing a shared vision for the city, with a healthy plan and work on specific themes; and (d) investment in formal and informal networking and cooperation. The concept is founded on the moral and political beliefs that inequalities in social conditions (and therefore health) are unjustified and that their reduction should be an overriding public health objective. While the entry point of the Healthy Cities approach is health, its underlying rationale has always been based on a model of good urban governance, which includes broad political commitment, intersectoral planning, citywide partnerships, community participation, and monitoring and evaluation.

The Healthy Cities principles draw on various work on the social determinants of health, notably studies initiated by Thomas McKeown. However, its proponents rightly diverged from McKeown's overemphasis on the "invisible hand" of improved nutrition at the expense of various types of important social interventions, such as improvements in living and working conditions, public education, medical science, democratic governance, public health practices, and human rights. The International Healthy Cities Foundation partners are drawn from leaders in these sectors.

The strategy also takes account of the increasing recognition of the complex effects of urbanization on health. Rapidly growing cities in Africa, Asia, and the Americas constitute the majority of the 300 cities with over one million inhabitants. While poor people in urban cities operate under the most life-threatening living and working conditions, their high concentration nevertheless provides opportunities for improving health: economies of proximity greatly reduce unit costs for provision of piped water, sewers, rubbish collection, immunization services, schools and public transport. Recent United Nations statistics estimate that, by 2007, more than half of the world's population will live in urban areas. Thus, Healthy Cities may be viewed as a set of public health strategies of potential benefit to more than half the people in the world.

Now in its second decade, a number of important achievements have been attributed to this approach. For example, California's Healthy Cities and Communities programme, which began in 1987, has contributed significantly to improving the state's health profile through a multitiered strategy that includes technical assistance, funding, promotion, coordination and collaboration, systems reform, programme evaluation, and recognition.

However, the effectiveness of Healthy Cities has largely been confined to industrialized countries, for a number of reasons. First, although its proponents acknowledge that conventional public health projects for the prevention or treatment of diseases did not adequately take account of health risks such as poverty, urban violence and terrorism, the predominantly functionalist health promotion framework within which the Healthy Cities approach operates makes it less likely to focus effectively on these underpinnings of "unhealthy" cities. Indeed, a paradox associated with the health promotion framework is that it inadvertently aggravates health inequality, because its messages are more likely to be put into practice by affluent communities.

Second, the twin crises of capitalist globalization — ecological unsustainability and social class polarization — have had a particularly deleterious effect on the health of city-dwellers in developing countries, including poor communities with hitherto exemplary health systems such as Kerala. Powerful economic and political interests in many countries, rich and poor, have displaced a welfare ideology with a neoliberal ideology, making it even more difficult to deal with those activities that make poor city-dwellers unhealthy. Because poverty is more extreme among the urban population in developing countries, the impact of globalization in poor communities is more adverse. As class polarization extends to rich countries, similar trends develop. In today's Toronto, for example, homelessness is at levels not seen since the 1930s and food bank usage has doubled since 1990, at a time when the Canadian economy continues a strong recovery.

Third, rising levels of urban violence and terrorism have made many cities unhealthy. In Brazil, for example, the benefits

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of a dramatic fall of 30% in infant mortality between 1990 and 2000 were completely wiped out by violence-related mortality. Both violence and terrorism promote insecurity, ethnic profiling, loss of community ethos and loss of civil liberties, factors that adversely impact on Healthy Cities activities. Indeed, travel warnings may be used as a proxy indicator of the global effectiveness of the Healthy Cities approach — most of the cities described as "unfit to live in" by the USA and the European Union are countries with high levels of violence and terrorist activity.

Fourth, the supportive environments that made the Healthy Cities approach effective in most industrialized countries — socioeconomic development, environmental sanitation, health education and primary health care — are skeletal in poor communities. Most consultants visiting poor countries such as Cambodia have consequently tended to focus on "soft" Healthy Cities components, for example Healthy Markets and Healthy Schools, and even these very limited activities are hardly sustainable.

Fifth, in spite of its rhetoric, the strategy's research base remains poorly developed, partly because such research is conceptually and practically difficult and partly because the Healthy Cities ethos has been characterized more by action than by reflection. The objectives are often expressed in idealistic terms: "ownership" and "empowerment" are not easily measured, and changes sought in local cultures and community attitudes may take generations to achieve. Even then, it would be difficult to disentangle the effects of other confounders from the results contributed by the Healthy Cities approach.

Sixth, although Healthy Cities is formulated as a global movement, its innovations are difficult to generalize, since they are meant to respond to local needs and priorities and these vary widely between poor and rich communities.

Finally, health promotion per se has played, generally, a secondary role in most of the collaborative achievements of the Healthy Cities approach. As Edwin Chadwick bitterly discovered after being denied another term as head of England's Health Board, *"The parliamentary agents are our sworn enemies, because we have reduced expenses, and consequently their fees, within reasonable limits. The civil engineers also because we have selected able men, who have carried into effect new principles, and at less salary. The College of Physicians, and all its dependencies, because of our independent action and singular success in dealing with the cholera, when we have proved that many a Poor Law medical officer knew more than all the flash and fashionable doctors of London. All the Boards of Guardians, for we exposed their selfishness, their cruelty, their reluctance to meet and relieve the suffering poor, in the days of epidemic. Then come the water companies, whom we laid bare and devised a more efficient method of supply ..."* By overemphasizing the impact of this concept on global health improvement, its custodians appear as "guilty" as the medical profession, accused by McKeown of attributing major advances in health in the past two centuries to advanced medical care.

The Healthy Cities approach is unlikely, in its present form, to remain a truly effective global health promotion tool this decade, in view of the considerations highlighted above. Given that the health promotion framework may inadvertently promote health inequality, it is important to develop more structurally appropriate frameworks for such global movements. Such alternative frameworks should prompt workers to advocate actively against policies that may undermine their programmes (e.g. erosion of civil liberties under the guise of fighting terrorism).

Furthermore, as the approach metamorphosed from a few European cities into a global instrument, the very nature of the — admittedly impressive — problems being tackled (e.g. social development and equity) made formal evaluation difficult. Nevertheless, some aspects, such as risks and protective factors, can, and should, be measured and the results published.

As Trevor Hancock and Ilona Kickbusch, the architects of Healthy Cities, reiterate, the challenge we face in cities is no longer how to understand the links between health, environment and the economy, nor to understand threats to sustainability: the challenge is to put into practice what we already know. Practical, evidence-based, context-specific interventions that can improve the health of the majority of the world's city-dwellers are more important than public health shibboleths. ■

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